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# "An oedipal conflict on an epileptic basis": the diagnosing and treatment of behavioural problems in a Dutch child psychiatric clinic (1952–1962)

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**ABSTRACT**

This article discusses the diagnosing and treatment of behavioural problems in a pioneering Dutch child psychiatric clinic in the 1950s. This was headed by Theo Hart de Ruyter, the first Dutch professor of child psychiatry and a psychoanalyst. It is generally assumed that during postwar years child psychiatry was primarily influenced by Freudianism with its focus on a nurture-related aetiology of children's behavioural problems. This assumption has, however, not been tested for the clinical practice. Did nature-bound explanations – referring to a child's neurological constitution, hereditary predisposition or brain dysfunction – disappear from the consulting room and was treatment with psychotropic drugs anathema to Freudians, in the way it has been suggested? We compare Hart de Ruyter's theoretical work with the contemporary expert discourse and with the way he and his team diagnosed and treated children, using clinical records. It turns out that both theory and practice and both aetiology and treatment mixed up nature and nurture. The use of an electroencephalogram to rule out organic causes and of medication to speed up improvement of a child's behaviour does, however, not undo the predominant adherence of the clinic's staff to updated versions of Freudianism. It also demonstrates the semi-improvisational nature of early academic child psychiatry.

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## Introduction

Like in many other countries, in the Netherlands academic child psychiatry did not mature as an independent field of knowledge until after World War II.[1] As elsewhere, there was a strong connection between its theory and the clinical practice that developed from the late 1920s in the outpatient child guidance clinics. These were modelled after the American example and staffed with a multidisciplinary team including a child psychiatrist and a psychiatric social worker. By treating children's behavioural problems they aimed to prevent more serious trouble during adolescence.[2] These clinics were the

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[1]Helmut Remschmidt and Herman Van Engeland, eds., *Child and Adolescent Psychiatry in Europe: Historical Development, Current Situation, Future Perspectives* (Darmstadt: Steinkopff Verlag, 1999).

[2]Kathleen W. Jones, *Taming the Troublesome Child: American Families, Child Guidance, and the Limits of Psychiatric Authority* (Cambridge MA: Harvard University Press, 1999); John Stewart, *Child Guidance in Britain, 1918–1955: The Dangerous Age of Childhood* (London: Taylor & Francis, 2013).

training ground for the first generation of child psychiatrists, some of whom were appointed as the first university professors of child psychiatry.[3] On the basis of their publications it is generally assumed that during postwar years these psychiatrists were primarily influenced by Freudianism and related theories, such as John Bowlby's attachment theory, with a focus on a nurture-related aetiology of children's behavioural problems.[4] This assumption has, however, not been tested for the clinical practice. How did child psychiatrists diagnose and treat children in these heydays of belief in the possibilities to understand children's problems primarily in terms of their early childhood affective experiences? Had nature-bound explanations, such as those referring to a child's neurological constitution, hereditary predisposition, organic or brain dysfunction – the ones that predominated before Freudianism's advance and do prevail today – disappeared completely from the consulting room? And was treatment with psychotropic drugs anathema to these nurture-focused Freudians, in the way it has been suggested?[5]

To study the diagnosing and treatment of "problem" children in the 1950s in the Netherlands, this paper discusses the clinical practice in the child psychiatric clinic of the Groningen University Hospital. This pioneering clinic was set up in 1952 by the first Dutch university professor of child psychiatry, Theo Hart de Ruyter. He had trained as a psychoanalyst and practised in child guidance clinics before he was invited to teach at the university. The clinic's services were similar to those of an American child guidance clinic: diagnosis and treatment by a psychiatrist, observation and testing by a psychologist, and, from 1956, information gathering about the family and counselling of the parents by a social worker. Because the clinic was part of an academic hospital there was the additional possibility of making an electro-encephalogram (EEG) of a child's brain to support a diagnosis.[6]

Although it is clear that Hart de Ruyter and most other Dutch pioneers in child psychiatry were strongly influenced by psychoanalysis and related theories that search for the causes of a child's trouble first of all in the interaction with the environment (nurture), several authors have warned against the drawing of a one-sided picture. The predominance of Freudianism did, for example, not imply that organic causes (nature) of childhood problems were overlooked by all child psychiatrists or neurologists and in all fields where they practised. In the postwar years, some of them, particularly those

[3]Leonie de Goei, *In de kinderschoenen. Ontstaan en ontwikkeling van de universitaire kinderpsychiatrie in Nederland, 1936–1978* (Utrecht: NcGv, 1992).

[4]Marijke Gijswijt-Hofstra and Roy Porter, eds., *Cultures of Psychiatry and Mental Health Care in Postwar Britain and the Netherlands* (Leiden: Rodopi, 1998); Timo Bolt and Leonie de Goei, *Kinderen van hun tijd. Zestig jaar kinder- en jeugdpsychiatrie in Nederland 1948–2008* (Assen: van Gorcum, 2008); Harry Oosterhuis and Marijke Gijswijt, *Verward van geest en ander ongerief*. Vol. I: *Psychiatrie en geestelijke gezondheidszorg in Nederland (1870–2005)* (Houten: Bohn Stafleu van Loghum, 2008), 637–44, 684–91.

[5]Bolt and de Goei, *Kinderen*, 67–8; Ruud Abma and Ido Weijers, *Met gezag en deskundigheid. De historie van het beroep psychiater in Nederland* (Amsterdam: SWP, 2005), 148–9; Toine Pieters, M. te Hennepe and M. de Lange, *Pillen & psyche: culturele eb- en vloedbewegingen. Medicamenteus ingrijpen in de psyche* (Den Haag: Rathenau Instituut, 2002), 21, 64–6. In the US medication was used earlier, from the 1950s, and more readily than in Europe in the treatment of hyperactive children: Seija Sandberg and Joanne Barton, "Historical Development," in *Hyperactivity and Attention Disorders of Childhood*, ed. Seija Sandberg (Cambridge: Cambridge University Press, 2002), 1–29. The Dutch Health Council warned against the use of medication for overactive children as late as 1985: Nelleke Bakker, "Brain Disease and the Study of Learning Disabilities in the Netherlands (c. 1950–85)," *Paedagogica Historica* 51, no. 3 (2016): 350–64.

[6]EEGs of children's brain activities were reported from 1953 in the dossiers of the Groningen Child Psychiatric Clinic. This device was introduced from 1948 in Dutch academic hospitals and a few specialised clinics: A.E.H. Sonnen, *Epilepsie en EEG* (Arnhem: CIBA-Geigy, 1982).

who declined Freudianism and presented themselves first of all as physicians, referred to brain damage as possible cause of learning problems and lack of attention at school.[7] Even the psychoanalyst Hart de Ruyter pointed to organic next to environmental causes of learning problems, attention disorders, and depression in selected writings from his long academic career. Certain organic dispositions could make a child more "vulnerable" than others to negative and "neuroticizing" environmental influences, he explained.[8] Do we recognise such a mixed aetiology in this clinic's work in the 1950s?

To answer this question we confront Hart de Ruyter's clinical work with his theoretical writing, both textbooks and journal articles. His clinical practice could be studied thanks to the availability of a sample of the dossiers (181) of this child psychiatric clinic from the 1950s and early 1960s, covering the years 1952 to 1962.[9] We focus on the three problems that were most frequently presented to him and his staff in those years: school problems, bed-wetting and anxiety. We compare his theoretical work on these issues with the contemporary expert discourse and with the way he and his team diagnosed and treated children. The focus is pointed to the balance between nature and nurture as regards the assumed cause of the trouble and starting point for treatment. To do this we first discuss child psychiatry in the Netherlands in the 1950s. Next, we go into Hart de Ruyter's theoretical work in general and his conceptualisations of these problems in particular. Finally, we discuss his clinical practice.

## Child psychiatry in the 1950s

In 1948, in the Netherlands, even before the first academic chairs in the new branch of knowledge had been endowed, a Section Child Psychiatry was established within the Dutch Society for Psychiatry and Neurology.[10] In the next years child psychiatry rapidly expanded into the fields of special education, youth care and care for "feebleminded" children. The authority of the pioneering child psychiatrists, Hart de Ruyter among them, was based on science-based manuals for professionals and it was relatively undisputed.[11] This in turn reinforced the process of medicalisation of child-rearing expertise by presenting behavioural problems as mental illnesses that had to be treated by a physician instead of an educator. Medicalisation of children's maladaptation developed parallel to the dissemination of the child-guidance point of view, according to which childhood behavioural problems needed treatment as early as possible to prevent initial unresolved emotional conflicts ("neuroses") from becoming serious mental ill-health.[12]

[7]Bakker, "Brain Disease"; Ido Weijers, "Zestig jaar kinder- en jeugdpsychiatrie in Nederland (1920–1980)," *Kind en Adolescent* 23 (2002): 82–96.
[8]Edo Nieweg, "Van kinderanalyse tot Y-chromosoom. Over eenzijdigheid in de psychiatrie," *Tijdschrift voor Psychiatrie* 12 (2000): 887–994.
[9]We would like to thank Accare for the opportunity to study these dossiers, that are still kept at the attic of the Child Psychiatric Clinic of the Groningen University Medical Centre.
[10]Bolt and De Goei, *Kinderen*, 18.
[11]Weijers, "Zestig jaar".
[12]Jones, *Taming*; Stewart, *Child Guidance*; Nelleke Bakker, "The Discovery of Childhood Mental Illness: The Case of the Netherlands c. 1920–1940," *IJHE – Bildungsgeschichte – International Journal for the Historiography of Education* 7, no. 2 (2017): 191–204.

The first generation of child psychiatrists identified with the movement out of which the child guidance clinics had grown in the early years of the twentieth century in the United States: the Mental Hygiene Movement, that focused on the prevention of mental illness. Childhood was its key interest, as leading "psychohygienists" subscribed to the Freudian concept of pathogenicity of infantile experiences.[13] For the Netherlands this focus on childhood is illustrated by the programme of the first National Congress on Mental Health in 1947, where four out of seven sections discussed childhood and the family.[14] And it is mirrored in the rapid increase of the number of child guidance clinics, from eight in 1946 to no less than 75 in 1962.[15] The worldwide approval of John Bowlby's World Health Organisation (WHO) report on *Maternal Care and Mental Health* (1951) reinforced the focus on childhood as a risky stage in an individual's life, presenting maternal deprivation in early childhood as a major threat to a lifetime of good mental health.[16] The psychoanalytic movement, large parts of which had moved from Vienna to London, likewise reoriented towards the mother–infant relationship,[17] a shift that fitted the conservative Netherlands with its dominant family-wage model[18] even better than the country in which many of the new theories developed.

The towering interest in mental health made the family and child-rearing the starting point for Dutch activists who wanted to combat an assumed post-war "moral crisis", that was traced back to the suddenly soaring rates of illegitimacy and marriage breakup. It was generally believed that a "moral regeneration" of family life was necessary to prevent youth from sliding down into delinquency or prostitution.[19] That is why expectations as to psychiatrists' contribution to this regeneration were high and child guidance clinics were recognised as a major weapon in the battle against social disruption and immorality. The Dutch practice departed from the American model in that paediatrics had also been represented in the multidisciplinary teams from the beginning, whereas psychologists were not. They joined the teams only after the war, when more various kinds of testing and qualified psychologists became available.[20]

The kind of problems that were presented at these clinics were – to use the American psychiatrist Douglas Thom's words – the "everyday problems of the everyday child".[21] Clients struggled with nervousness, bed-wetting, aggression, anxiety, stealing, and learning problems, which were treated primarily on the basis of a mixture of psychoanalytic (both Freudian and Adlerian) concepts. In the Dutch case the paediatrician examined the child physically and, in case of a suspicion of mental retardation, IQ-tested it. When

[13]Theresa Richardson, *The Century of the Child: The Mental Hygiene Movement and Social Policy in the United States and Canada* (New York: SUNY Press, 1989).
[14]*Nationaal Congres voor de Geestelijke Volksgezondheid* (Zwolle: Erven J.J. Tijl, 1947).
[15]Tom van der Grinten, *De vorming van de ambulante geestelijke gezondheidszorg. Een historisch beleidsonderzoek* (Baarn: Ambo, 1987), 186–209.
[16]John Bowlby, *Maternal Care and Mental Health: A Report Prepared on Behalf of the World Health Organization as a Contribution to the United Nations programme for the Welfare of Homeless Children* (Geneva: World Health Organisation, 1952).
[17]Eli Zaretsky, *Secrets of the Soul: A Social and Cultural History of Psychoanalysis* (New York: Knopf, 2004), 249–75.
[18]Nelleke Bakker, Jan Noordman, and Marjoke Rietveld-van Wingerden, *Vijf eeuwen opvoeden in Nederland. Idee en praktijk 1500–2000* (Assen: Van Gorcum, 2006), 231–40.
[19]Ibid., 237–40.
[20]Child guidance clinics, imported from the US in the late 1920s, departed from the general pattern in Dutch child welfare – following German examples until World War II and American ones thereafter. Before the war few (child) psychologists had been available: Bakker, "The Discovery"; Van der Grinten, *De vorming*.
[21]Douglas Thom, *The Everyday Problems of the Everyday Child* (New York: Appleton, 1927).

available a psychologist tested other qualities such as attention (with a Bourdon test) and character (with Rorschach). The psychiatrist observed a young child's play and drawings and listened to an older child's stories for a diagnosis and treated the child with play therapy or psychotherapy after the "unconscious feelings" that were bothering her/him were discovered. The psychiatric social worker, the only full-time employee, had trained in social casework. She was responsible for the gathering of information on the child's history and family, and – after the diagnosis – for counselling the parents, as the cause of the trouble was most often found in "child-rearing faults". These could be repaired, child guidance professionals believed, by making parents change their child-rearing style (the so-called "influencing of the environment").[22]

## A theoretical omnivore

In his theoretical work Hart de Ruyter showed a comparable therapeutic optimism. Throughout the 1950s he defended the possibility of successful psychiatric treatment of even the most difficult children. In therapy, he claimed, he could go back to the pre-oedipal stage (between eight months and three years of age) in cases of unfulfilled hunger for affection and redress the child's adverse emotional development, the way he had learned to do at the child guidance clinics.[23] That is why he persistently opposed the concept of a "child psychopath", refusing to accept the untreatability of so-called "hopeless cases". Many of the most difficult cases were, he insisted, "affectively neglected" neurotics, who were ill but correctible and needed psychiatric treatment to reinforce their weak Ego and underdeveloped Super-Ego. Illness of this kind manifested itself especially during the pre-adolescent stage, between 10 and 12 years of age, when a healthy Ego and Super-Ego were bound to ripen.[24] His optimism explains why Hart de Ruyter was a dedicated defender of democratic relationships between parents and children and in children's homes, as authority would inspire the kind of scare that precluded a child from showing her/his true self and produce would-be adaptation, which in turn would prevent therapeutic success.[25]

The inspiration for this theoretical position was taken from a body of very different, mostly recent and at face value incompatible psychological and psychiatric theory from across the Western world. According to Hart de Ruyter, inborn physical and mental characteristics, such as a child's temperament, mattered in

[22] Jones, *Taming*; Bakker, "The Discovery"; Petronella H.C. Tibout, *Over de indicatiestelling bij de behandeling van kinderen met afwijkend gedrag. Psychiatrisch-sociale beschouwi*ngen (Muusses: Purmerend, 1948).

[23] Tibout, *Over de indicatiestelling*; Th. Hart de Ruyter, *Problemen rond de kinderpsychotherapie* (Groningen/Djakarta: Wolters, 1956); G. Mik, "Over de klinische behandeling van ontwikkelingspsychopathologie bij kinderen," *Tijdschrift voor Psychiatrie* 11 (1969): 178–97.

[24] Th. Hart de Ruyter, "Die Differentialdiagnose der konstitutionellen Psychopathie und Erziehungsschwierigkeiten," in *Proceedings of the Second International Congress on Orthopedagogics*, ed. I.C. van Houte and B. Stokvis (Amsterdam: Systemen Keesing, 1950), 298–313; Th. Hart de Ruyter, *Over de plaats van de kinderpsychiatrie in de geestelijke gezondheidszorg* (Groningen: Wolters, 1953); *Problemen*; Th. Hart de Ruyter, "Affectieve relatiestoornissen," *Maandschrift voor Kindergeneeskunde* 26 (1959): 357–71; Th. Hart de Ruyter, "De taak van de psychiater bij de kinderbescherming," in *Handboek voor de kinderbescherming* (Rotterdam: Nijgh & Van Ditmar, 1951), 239–61; Th. Hart de Ruyter, "De jeugdpsychiater," in *Jeugd en Samenleving* III. *Handboek voor de bijzondere jeugdzorg* ('s-Gravenhage: Nijgh & Van Ditmar, 1959), 244–63.

[25] Th. Hart de Ruyter, "Over het autoritaire beginsel in de opvoeding," *Tijdschrift voor Maatschappelijk Werk* 11 (1957): 293–9; Th. Hart de Ruyter, *Moeders en kinderen* (Nijkerk: Callenbach, 1959); Th. Hart de Ruyter, *De vader van het kind* (Nijkerk: Callenbach, 1959).

that some personality types were more susceptible than others to mental illness. In this respect he referred to constitutional psychologists of the early and mid-twentieth century, particularly the Dutchman Gerard Heymans, the German Ernst Kretschmer, and the American William Sheldon, from whose studies he took the descriptions of particularly "risky" temperaments, such as the "nervous" (Heymans), the "cyclothymic" (with a "pyknic" physiology, according to Kretschmer), the "schizothyme" (with a "leptosome" physiology, according to Kretschmer) and the "oversensitive" (Sheldon) ones.[26] As regards the stages of development, however, he showed himself a real Freudian in distinguishing the oral, anal, phallic, oedipal, latent, and (pre-)adolescent stages, during which a child progressed from the first impulses towards gratification to a gradual sublimation of lust based on the love for his/her mother, on the basis of which the Ego could develop towards adaptation of his/her behaviour to the demands of the wider community, that would be internalised by his/her developing Super-Ego.[27]

Anna Freud was Hart de Ruyter's prime source of inspiration concerning the analysis of a child, the coping strategies ("defence mechanisms") a child might develop, as well as the determination of a(n) (un)healthy development by infantile affective relationships.[28] As regards early childhood he adopted theories of other psychoanalysts, such as Melanie Klein, Margaret Ribble and René Spitz. Although in different ways, they all emphasised the infant's essential need for motherly love and affection.[29] He linked up these ideas with the views of the Viennese psychoanalyst August Aichhorn, who worked with institutionalised "problem" youths, whom he diagnosed as "affectively neglected" during infancy because of a broken home or having been raised in a children's home.[30] Soon after Bowlby's WHO report had appeared, Hart de Ruyter referred to the "undeniable connection between affective neglect in the first years of life and disorder of the conscience" as a well-known fact among child psychiatrists that had now been statistically verified.[31]

Following Bowlby and related theorists, Hart de Ruyter insisted time and again that most behavioural problems (he estimated that it was three quarters) had their origin in "early affective neglect".[32] This had frustrated the healthy growth of "basic security" – a concept he said he derived from Erik Erikson[33] – in the pre-oedipal stage of development. It manifested itself as "insufficient", "narcissistic", or "ambivalent" relational disorder,[34] to which he added a "symbiotic" and an "autistic" variety at the end of

[26]Hart de Ruyter, "Die Differentialdiagnose"; Th. Hart de Ruyter, *Inleiding tot de kinderpsychologie*, 2nd ed. (Groningen: Noordhoff, 1955), 21–9.
[27]Th. Hart de Ruyter, *Inleiding tot de kinderpsychologie* (Groningen: Noordhoff, 1952), 32–82; *Inleiding* (1955), 38–94; Th. Hart de Ruyter, *Inleiding tot de kinderpsychologie*, 3rd ed. (Groningen: Noordhoff, 1959), 41–101.
[28]He referred to Anna Freud, *Das Ich und the Abwehrmechanismen* (London: Imago, 1946); Dorothy Burlingham and Anna Freud, *Kinderen zonder eigen thuis* [translation of *Infants Without Families*] (Amsterdam: Scheltema & Holkema, 1949); Anna Freud, *De psycho-analytische behandeling van kinderen* (Amsterdam: De Spieghel, 1950).
[29]Hart de Ruyter, *Inleiding* (1952), 34, 140. In the chapter on the pre-oedipal phase he referred to René Spitz and Melanie Klein, in the one on "Child-rearing faults" to Margaret Ribble. For the differences between their theories: Claudine and Pierre Geissmann, *A History of Child Psychoanalysis* (London: Routledge, 1998).
[30]Hart de Ruyter, *Inleiding* (1952), 40; August Aichhorn, *Verwahrloste Jugend* [1925], translated as *Verwaarloosde jeugd. De psychoanalyse in de heropvoeding* (Utrecht: Bijleveld, 1952).
[31]Hart de Ruyter, *Inleiding* (1955), 126. See also Hart de Ruyter, *Over de plaats*; *Problemen*; *Moeders*; "Affectieve relatiestoornissen".
[32]Hart de Ruyter, "Affectieve relatiestoornissen," 362.
[33]Ibid., 363. He refers to Erik Erikson, *Childhood and Society* (London: Hogarth Press, 1951).
[34]Hart de Ruyter, *Inleiding* (1952), 112–14.

the 1950s.[35] All of these were caused by a mother's lack of involvement, absence (including death), or ambivalent love. And all of these kinds of neuroticism could be treated successfully with psychotherapy. For a young child, play observation and drawings of trees were indicated as diagnostic instruments; (pre-)adolescents could tell their stories, interpret Rorschach inkblots, write down fantasies about their future ("Me and the world in twenty years") or complete incomplete stories or sentences, to find out what unconscious feelings, next to their character dispositions, they were struggling with.[36]

However, not all childhood behavioural problems were of a neurotic kind or caused by inadequate mothering, according to Hart de Ruyter. Of the problems that bothered the wider community as much as the child and her/his parents themselves (the so-called "psychopathies", such as aggressive behaviour), that manifested themselves usually not before pre-adolescent years, some were caused by brain damage and some by "constitutional disharmonies" that implicated an unfavourable predisposition, such as a "schizothyme" temperament, Hart de Ruyter explained in a chapter on child psychiatry in the two editions of the new handbook for childcare professionals that appeared in the 1950s. Even these problems could be treated with psychotherapy, individually or in a small group, though prospects were less positive than in case of neuroticism.[37] Treatment with medication was mentioned only in a short paragraph, both in 1951 and in 1959. In case of adolescent "hyper-sexuality", i.e. boys' excessive masturbation and girls' premenstrual trouble, "hormone therapy" might be useful, according to Hart de Ruyter, to mend the adolescent endocrine instability. It could also be applied in case of a glandular background of mental retardation, he added in the 1959 edition. Epilepsy, he explained in this edition, could be treated with anti-epileptic drugs, while other kinds of medication might "sometimes" be useful to support psychotherapy's effectiveness, an option that had been "hardly ever necessary" in 1951. As regards medication to stimulate "brain metabolism", the psychiatrist showed less restraint: it might be useful "in certain cases".[38]

In 1952 Hart de Ruyter published his *Inleiding tot de kinderpsychologie* [Introduction to child psychology], that would be reprinted for more than 20 years, during which it was widely used.[39] Three, largely identical, editions appeared in the 1950s.[40] The textbook was meant for students and professionals in education, social work, parenting support, and child and youth care. The larger part of the information is organised according to the stages of development and their characteristics, in which he leaned on both Anna Freud and Jean Piaget. There are chapters on infancy, early childhood, school-age, pre-adolescence, and adolescence, in which he also discusses stage-related developmental hurdles and their aetiology, such as toddlers' stubbornness (the Austrian-American developmentalist Charlotte Bühler's *Trotzalter*) and pre-adolescents' opposition and negativity (Bühler's negative phase). Other chapters cover human physiology, especially the nervous system, the "abnormal" child (i.e. various

[35]Hart de Ruyter, "Affectieve relatiestoornissen".
[36]Hart de Ruyter, "De taak"; "De jeugdpsychiater".
[37]Hart de Ruyter, "De taak"; "De jeugdpsychiater".
[38]Hart de Ruyter, "De taak," 252–3; "De jeugdpsychiater," 256–7.
[39]This amounted to seven editions, the latest published in 1973.
[40]Hart de Ruyter, *Inleiding* (1952); *Inleiding* (1955); *Inleiding* (1959).

kinds of handicapped children and their schools), the abnormal development of normal children caused by the environment (such as "pathogenic families", and step- and foster-children), some child psychiatric illnesses (such as autism), "child-rearing faults" and their possible consequences (such as bad sleep, bed-wetting and delinquency), and the practice of diagnosing and treating children at a child guidance clinic. Childhood behavioural problems and their aetiology figure prominently in this book and each of the three problems that were most frequently presented at his clinic is discussed in one or more chapters.

## School problems

According to Hart de Ruyter's textbook school problems of normally gifted children had other causes than a low IQ. We learn that children of normal intelligence could fail at school because of many reasons: physical illness, a sensory disorder, congenital word blindness, an unfavourable temperament, a developmental delay, a disharmonious family, or emotional conflict – of which only the latter two were of a neurotic kind. In case of a developmental delay a child might seem mentally retarded, but it was not, because it would catch up. It implied that (s)he matured late and trailed behind his/her peer-group, which might cause – in the individual psychologist Alfred Adler's words – "discouragement". The delay could have a genetic cause and it could recover spontaneously. Children with specific learning problems or "partial defects", such as congenital reading problems, needed to be treated in the kind of special school that was created recently for children struggling with these defects,[41] because a regular school could mean a "torture" for them and produce "discouragement", he insisted. However, school problems could also be caused by unresolved emotional conflicts. These "neurotic" learning problems were caused by an unfavourable environment, such as a "neurotic family", and they could likewise produce "discouragement" in case they remained untreated.[42] A novel element in the third (1959) edition of the textbook was the mentioning of two more organic or neurological causes of learning and related behavioural problems, epilepsy and brain damage, which were said to produce a low level of frustration tolerance and fierce and uncontrolled expressions.[43]

In one of the two popular parenting books Hart de Ruyter published in 1959, he elaborated on the nurture-bound causes of school problems such as parental demandingness, by presenting a father who wants his moderately intelligent son to perform well at school. He ignores the disappointing result of an IQ test and starts tutoring his son himself, with the consequence of truancy, street wandering, and finally, thanks to the juvenile judge, treatment at a child guidance clinic, where the team succeeds in making the father accept his son and his limited academic performance.[44]

Compared to a more specialised textbook for students and teachers working with "abnormal" children by another child psychiatrist, Reinier Vedder, Hart de Ruyter paid little attention to learning problems and gave more credit to neuroticism as cause.

[41]Nelleke Bakker, "A Culture of Knowledge Production: Testing and Observation of Dutch Children with Learning and Behavioural Problems (1949–1985)," *Paedagogica Historica* 53, no. 1-2 (2017): 7–23.
[42]Hart de Ruyter, *Inleiding* (1952), 88–92; *Inleiding* (1955), 102–6; *Inleiding* (1959), 113–19.
[43]Hart de Ruyter, *Inleiding* (1959), 118–19.
[44]Hart de Ruyter, *De vader*, 37–8.

Vedder discussed topics related to organic causes of school failure – such as partial defects, developmental delay, attention deficit, hyperactivity, and epilepsy – much more extensively.[45] This focus on organic causes is in accordance with developments in the international community of researchers in the field of special education. At the Second International Congress on Orthopedagogics in 1949 in Amsterdam, for example, the participants of the section on pupils struggling with "partial defects" emphasised organic causes to such an extent that the reporting psychiatrist claimed that these could all be considered "brain injured children".[46] Dutch experts involved with the new kind of special school for learning-disabled children of normal intelligence likewise discussed organic and neurological causes frequently.[47] This interest was fed by an academic strand that was reinforced in the 1950s by developments in American neurology, which elaborated on Alfred Strauss' work on "brain-damaged" children and the experiments with amphetamine in their treatment, and by the introduction of EEG-based research techniques, both of which supported claims regarding a brain-related aetiology and a biomedical approach to learning and behavioural problems.[48] These tendencies could not be ignored and had been discussed by Dutch experts for some time before Hart de Ruyter included them in the 1959 edition of his textbook.

## Bed-wetting and anxieties

According to Hart de Ruyter's textbook, bed-wetting could be caused by physical abnormality, illness, exhaustion, or any other constitutional condition. But these were the exceptions. More often the problem of toilet-trained children who fell back in wetting their beds at night, which he discussed in the chapter on child-rearing faults, was caused by (pre-)neuroticism. Toddlers could wet their beds because of stubborn resistance and as a reaction to affective neglect. Neurotic bed-wetting always was an expression of anxiety, the textbook warned. That is why aggressive treatment was bound to fail. Instead, psychotherapy and positive parenting were indicated. In some cases – but each one was different – medication, a diet, or special gymnastics might help.[49] Other experts, school doctors among them,[50] agreed that bed-wetting had as a rule a neurotic background and was, therefore, curable. It could be a sign of jealousy, for example when the arrival of a new sibling made a toddler feel neglected.[51] Too little or too much attention[52] or a mother's own anxieties[53] might equally cause a child to wet his/her bed at night.

Anxiety as a behavioural problem was likewise discussed in Hart de Ruyter's textbook's chapter on child-rearing faults. A "neurotic" child could experience strong and

[45]R. Vedder, *Afwijkende kinderen in de school* (Groningen: Wolters, 1958), 120; R. Vedder, *Kinderen met leer- en gedragsmoeilijkheden* (Groningen: Wolters, 1960), 42–4, 50–1, 62–3, 71–4, 76–8.
[46]P.H.C. Tibout, "Report of the Section Partial Defects," in *Proceedings*, 380–5, esp. 384.
[47]Bakker, "The Discovery".
[48]Sandberg and Barton, "Historical Development"; Bakker, "Brain Disease". For the EEG, see note 6.
[49]Hart de Ruyter, *Inleiding* (1952), 141–2; *Inleiding* (1955), 158–9; *Inleiding* (1959), 172–3.
[50]Bakker, "School Medical Inspection and the 'Healthy' Child in the Netherlands, 1904–1970," *History of Education Review* 46 (2017), no. 2, 164–77.
[51]Vedder, *Afwijkende kinderen*, 76, 120, 154; E.C.M. Frijling-Schreuder, "Psycho-analyse en opvoeding," *Maandblad voor de Geestelijke Volksgezondheid* 8 (1953): 334–43.
[52]I. Donker-Rutgers, "Conferentie Medisch Opvoedkundige Bureaux. Afstand Weerstand Bijstand," *De Koepel* 15 (1961): 74–9.
[53]A. de Leeuw-Aalbers, "Casuïstiek uit het kinderleven," *Maandblad voor de Geestelijke Volksgezondheid* 5 (1950): 307–13.

inhibiting fears due to his/her unsolved inner conflicts, Hart de Ruyter explained. Parents' strict demands or their own neuroses were likely causes. Fortunately, many anxieties were related to certain developmental stages and would, therefore, disappear naturally. Particularly during the transition from the oedipal (toddler's age) to the latency (school age) stage, anxieties were normal, he assured his readers. A child suffered from neurosis only in case they pertained. Punishment and constraint were counterproductive. Instead, parents should try to find the cause of the anxiety, be it a traumatic experience or feelings of insecurity, and encourage the child to overcome these feelings. Symptoms of anxiety could be many: bed-wetting, sleeping disorders, dreaming, stuttering, lying, aggression, and over-anxiety about her/his own physical well-being. However, less-worrying behaviour, like quietness or obedience, could just as well be a symptom of anxiety, ready to develop into full-blown neurosis. Affectively neglected children might suffer from sleeping problems due to anxieties. These should not be ignored and parents were advised to offer their child rest, show reliability and listen carefully to find out what was frightening the child. When the sleeping problems persisted, medication could help.[54]

In the second (1955) edition of the textbook Hart de Ruyter leaned even more heavily on Anna Freud, by discussing anxieties also as fruit of a child's "defence mechanisms". Too much parental support created a weak or helpless Ego, whereas too little support was responsible for a distorted, reality-denying Ego, he explained. Particularly, too strict demands could produce a dangerous "Ego limitation", from which "Lebensangst" and a frustrated sexuality would develop.[55] He mentioned both Aichhorn and Bowlby now in relation to anxieties caused by "affective neglect" during the pre-oedipal stage.[56] In the third (1959) edition Hart de Ruyter paid more attention to particularly Spitz's reading of the pre-oedipal stage as birth-ground of separation anxiety. Loss of maternal care or being cared for by too many would-be "mothers" makes a young child nervous and prevents the development of "basic security", we learn.[57]

In the expert discourse anxieties were likewise discussed as expressions of neuroticism, caused by "affective neglect" in early childhood.[58] Vedder, for example, showed his adherence to Freudianism by blaming overanxious mothers for pouring anxiety into their children and making them feel insecure. Neurotic inhibitions and unconscious feelings of guilt produced anxieties, he explained. Guilt in turn might express itself in aggressive behaviour.[59] A child-guidance-clinic psychiatrist warned particularly against "neurotic" mothers who could not accept their child and, as consequence, produced anxious children.[60] Fear of losing parental affection and fear of punishment were repeatedly mentioned as sources of all kinds of behavioural problems in which an "affectively neglected" child expressed her/his weak Ego. Cure depended on the recognition of the underlying emotions, psychoanalysts explained.[61] Fears, in other words,

[54]Hart de Ruyter, *Inleiding* (1952), 103, 116, 130, 136–7, 140–1.
[55]Hart de Ruyter, *Inleiding* (1955), 132.
[56]Ibid., 47, 126.
[57]Hart de Ruyter, *Inleiding* (1959), 43.
[58]L.M., "Een geval van affectieve verwaarlozing," *Mozaïek* 11 (1960): 84–6.
[59]Vedder, *Kinderen*, 190–1.
[60]A. de Leeuw-Aalbers, "Casuïstiek uit het kinderleven," *Maandblad voor de Geestelijke Volksgezondheid* 5 (1950): 307–13.
[61]A.J. de Leeuw-Aalbers, "De steun van de psychiater bij de inrichtingsopvoeding," *Maandblad voor de Geestelijke Volksgezondheid* 10 (1955): 416–29; E. Frijling-Schreuder, "Wereldbeschouwing en Psychotherapie," *Maandblad voor de Geestelijke Volksgezondheid* 6 (1951): 2–9.

were both a symptom and a source of neurosis, next to a product of a mother's neuroticism, whereas bed-wetting was one of its major symptoms.

## Diagnosing and treatment in a child psychiatric clinic

Hart de Ruyter had trained as a psychiatrist at one of the first Dutch child guidance clinics, in Haarlem, set up another one in Zaandam, and organised a Youth Psychiatric Service for the City of Amsterdam. In 1952 he was invited to teach child psychiatry at the northern University of Groningen, first as a lecturer and from 1956 as the first Dutch full professor in the subject. He practised at the University Hospital's psychiatric ward, where he claimed a few beds for children and started consulting hours for parents and children. In this way, he made available to the northern region the kind of care that was elsewhere provided by child guidance clinics.[62] To come even closer to this model of ambulatory help he managed to appoint a psychiatric social worker at his clinic in 1956 and made some of the nurses attend courses in social casework at the local School of Social Work.[63] Before the end of the 1950s his Child Psychiatric Clinic attracted large numbers of patients from all over the northern half of the country. By the mid-1950s waiting lists for EEG-examinations and admission freezes were the rule. Incidentally, patients from other regions were referred to the Groningen University clinic to receive a diagnosis from Hart de Ruyter and be treated, sometimes as a last resort in what other child psychiatrists seemed to think of as "hopeless cases". In 1961, finally, a child guidance clinic was established in Groningen, where Hart de Ruyter's trainees practised. The new clinic reduced the need for the university's outpatient services, while the demand for child psychiatric expertise in general continued to grow.

In the 181 dossiers from the years 1952 to 1962[64] that have been kept in the Groningen University child psychiatric clinic we find information mostly about the diagnosing of the children. It concerns test reports, drawings, short reports about intakes, letters to (with drug prescriptions) and from the children's general practitioners, advice to guardianship societies, letters from people involved with the referral of the child, and sometimes letters from parents or the children themselves. Information about the treatment is largely absent, apart from prescriptions of medication and advice as to the kind of psychotherapy or remedial teaching that was indicated for a particular child. When a child was treated with psychotherapy by Hart de Ruyter or one of his trainees, we are informed about this only occasionally and indirectly, by the mentioning in a letter that a child was hospitalised, observed and treated in the clinic for some weeks or by a series of short reports about periodic talks with an ambulatory child patient.

One case illustrates both the way another child psychiatric team's "hopeless case" could be re-evaluated by Hart de Ruyter and the occasional information on the kind of psychotherapy provided in his clinic. In 1953, 10-year old Sietse was referred to him by

[62]Only two provinces, Groningen and Zeeland, still had to do without such a clinic in 1957: E.C. Lekkerkerker, "Voorposten in de geestelijke gezondheidszorg voor kinderen," *Maandblad voor de Geestelijke Volksgezondheid* 12 (1957): 90–106.

[63]Dossier no. 60 (1957). See also, for the nurses: Geertje Dimmendaal, *Heropvoeding en behandeling. Meisjes in Huize de Ranitz, Groningen 1941–1967* (Groningen: Van Gorcum, 1998).

[64]We selected the 70 dossiers that concern cases of school problems (34), bed-wetting (25) and anxieties (18). We gave them numbers 1–77, as 7 dossiers concern children who were seen because of two of these problems.

the Amsterdam Child Guidance Clinic, which had treated him in vain for bed-wetting and problem behaviour over more than a year. The letter of referral of the very experienced child psychiatrist from Amsterdam, A. de Leeuw-Aalbers, reveals that her team considered him a "hopeless case". The "very seriously neurotic" boy was said to be "hardly treatable with therapy" and his parents were judged incapable of improving their attitude by means of "social casework". The boy was hospitalised in Groningen for 12 weeks, during which a neurological examination revealed a writing disorder and an EEG a regulative disturbance "close to epilepsy". The most important conclusion, however, concerned Sietse's ambivalent feelings towards his mother, that originated in "affective neglect" in his pre-oedipal years during which his father had been absent. These were said by Hart de Ruyter, in his report to the Amsterdam colleagues, to have been aggravated by fear of castration, against which he had defended himself by fantasies of greatness. His clinic's tolerant climate was said to have caused serious improvement of Sietse's fits of anger and aggressive behaviour and to have reduced his fantasising, while the medication (prominal-amphetamine) for his bed-wetting, interpreted as expression of an "organic (epileptic) regulatory disturbance", had been equally successful. He advised psychotherapy and continuation of the treatment with medication (prominal).[65]

## School problems

The 34 children who were diagnosed in the Groningen hospital because of problems at school were aged between 8 and 17 when they first visited the clinic, with an average age of 11. Twenty-one were boys and 13 were girls. At the time almost everywhere in the country school doctors were actively involved in hygienic support of primary and secondary schools.[66] This included the selection of pupils for special schools for "feebleminded" children, by means of an IQ test. Admission was limited to children with an IQ score below 70. Pupils who might qualify were usually tested at age seven or eight, after one or two years of unsuccessful primary schooling. Therefore, children who were referred to the child psychiatric hospital did not usually fail at school because of a low IQ. Only three children were qualified by the clinic's team as "feebleminded", while three more were IQ-tested with the Dutch version of the Binet-Simon test (Binet-Herderschêe) and found "weakly gifted" on the basis of an IQ score between 70 and 75, which was considered too low for adequate participation in ordinary schooling and too high for the school for feebleminded children. Two of the latter children were also qualified as having a developmental delay, next to four other children.

More often there were other reasons why a child failed at school. One was a partial defect or specific learning disorder, such as reading problems (called "alexia" or "word blindness" at the time), or problems with counting or writing. This was the case with six children. Another reason was attention deficit, which often went together with overactivity. This is true for 11 children, who today would be diagnosed with ADHD or ADD. In the 1950s in the larger cities of the Netherlands, children with partial defects or a short attention span could be referred to the new kind of special school for

[65]Dossier nos 9 and 42 (1954). The names in the text are pseudonyms.
[66]Bakker, "School Medical Inspection".

normally gifted children with learning and behavioural problems, a provision that was not yet available in countryside districts.[67]

Children with attention problems at school, especially those with a record of having hurt their skulls or having been unconscious for some time after falling, were as a rule examined with an EEG at the neurological department of the hospital to find out if they suffered from epilepsy. But other learning-disabled children were also EEG-examined; in our sample a total of 17 were subjected to this rather unpleasant experience. One gets the impression that it was done as a routine, just to be sure that a child did not suffer from epilepsy. Of the EEG-examined children only one was said to "possibly" suffer from epilepsy, one was diagnosed with "organic brain disease", 10 with no more than a "regulative disturbance" or a more or less "irregular brain function", and 5 with a perfectly normal brain wave pattern. Most of the children with one or another EEG-registered "irregularity" in the functioning of their brain, as well as some others (13 in total), received medication, sedatives such as luminal or prominal or a stimulant, such as amphetamine, or both. However, no more than nine children were explicitly said to suffer ("probably") from an organic brain dysfunction. In three cases, this was said to be the case next to neuroticism as cause of their failing at school, such as a "neurotic family". Of the 17 children who were said to fail at school because of "neurotic" problems, some nonetheless received medication, usually in cases when an "irregular brain function" had also been found. Therefore, biological (nature) and environmental (nurture) causes of and possible solutions for school problems were not mutually exclusive, while – against our expectation as to the psychoanalytic orientation of the head of the clinic – natural causes of school problems were both sought for actively through EEG-examinations and easily recognised by the clinic's staff on the basis of no more than vague indications.

Organic causes of school failure could also be assumed on the basis of hereditary predisposition. Although her EEG had not given any such indication, 15-year-old Tinie with a very low IQ-score (Binet-Norden, 50), was said to suffer from a "progressive brain dystrophy", because an uncle had been diagnosed with this illness.[68] A child's own history could likewise be interpreted in terms of heredity. Fifteen-year-old Ada had a sickly mother and grew up in a children's home. She had been bullied there for her lack of intelligence. She disliked school, bit her nails, showed aggression, and had wet her bed up to the age of 10. Hart de Ruyter was convinced that she had had a perinatal brain haemorrhage because her mother had already been ill at the time of her birth. Ada's EEG was not made in the end, because she had finally been placed in a friendly foster family, after which change of environment her mood and school work had improved considerably.[69]

Neurotic causes of a sickly aversion to school were even more easily assumed than organic ones. They could cooperate in reducing a child's learning capacity, as these two examples show. Despite the fact that his EEG did not show any irregularity, in the case of intelligent nine-year-old Henk an organic disposition was assumed on the basis of him having fallen hard at the age of six without having laid still during a full three

[67]Bakker, "A Culture".
[68]Dossier no. 2 (1955).
[69]Dossier no. 30 (1956).

weeks afterwards. He had started to walk back home from school twice a day without any obvious reason. Henk was tested extensively without any more significant results than Rorschach showing an "epileptic tendency" and his fantasy drawing of a tree showing an "aggressive tendency". This made Hart de Ruyter draw the conclusion that the boy was suffering from "an oedipal conflict on an epileptic basis". His aggression was directed at his parents, by whom he felt neglected. Henk's father threatened to beat him up, which made things even worse. For the psychiatrist the boy's walking back home was a symptom of his feelings of guilt towards his little sister, suggesting concern for her, instead of his real but unconscious feelings of aggression and jealousy.[70]

Eleven-year-old, unruly Henny, who opposed her teacher and fled from a "therapeutic" foster family, was diagnosed as emotionally disturbed to the extent that she lived in a constant condition of anxiety, which was assumed to have both an organic and a neurotic basis. Her EEG showed a disturbed regulation of the brain function and her sister was epileptic. According to the psychiatrist, the organic aspect of her anxiety prevented control of her impulses and fits of anger, whereas her neuroticism provided her with huge feelings of guilt about her ambivalent feelings towards her parents. The result was "would-be adaptation", which made Henny very difficult to handle in class. It was hoped that medication would help her control her wayward behaviour.[71]

Cases of pure neuroticism as cause of school problems, without signs of attention deficit, a partial defect, or even a slight irregularity of the brain function – in other words, purely caused by child-rearing faults – are few; only four. Twelve-year-old Tjeerd did not do well in his first year of vocational training at a technical school and was said to "dream away" often. He complained of pain in his legs and of belly aching. Because the paediatrician could not find a somatic cause of his pain, the boy was referred to the psychiatrist. Rorschach suggested epilepsy, but an EEG showed no abnormalities. Tjeerd was diagnosed as victim of his demanding father, "restrictive milieu", and infantile sensuality. These made him fear school in the way he feared the possible loss of his mother, and "experience school attendance as a trauma of separation", one of the clinic's young psychiatrists reported. Hart de Ruyter prescribed amphetamine for several years (1956–1960) because of the boy's depression, until this was no longer needed because the switch to a lower level of schooling made him feel much better.[72] This case may have inspired the example in his popular parenting book about a father who could not accept his son's low academic performance.

## Bed-wetting

The 25 child patients who struggled with serious and continued bed-wetting were aged between 8 and 14 when they first visited the clinic, with an average age of 11. Nineteen were boys, six were girls. Although bed-wetting was considered by experts to have primarily a "neurotic" background, the Groningen child psychiatric clinic performed an EEG in a majority (14) of these cases and 11 children were prescribed medication to make them sleep less deeply. In seven cases nothing abnormal was found, but seven

[70]Dossier no. 25 (1953).
[71]Dossier no. 28 (1955–1959).
[72]Dossier no. 3 (1956–1963).

other cases revealed traces of "regulatory disturbances" in the child's brain activity. One 15-year-old boy refused to undergo an EEG-examination and one boy was suspected of having acquired brain damage at the age of one, despite the fact that no EEG was made. This makes a total of eight children diagnosed with an "organic" cause of this most depressing and disturbing problem. In almost all of these cases neuroticism was also held responsible. Still, in the majority of the cases (10) with enough information about the diagnosis and the assumed aetiology (18) of the bed-wetting problem, neuroticism alone was held responsible.

It is remarkable that relatively many bed-wetting children came from incomplete families, had a stepmother or father, or lived in a foster family. These children were easily assumed to feel unloved and diagnosed as "affectively neglected" in their early childhood. One of these cases concerns 15-year-old Marie, who lived with an aunt after her mother had committed suicide when she was only six and she did not see much of her father, a bargeman. According to a Bourdon attention test Marie might have an "unstable organic foundation", but her childhood trauma and her lack of possibilities for identification were, according to Hart de Ruyter, an even more serious cause of Marie's anxiety for her developing sexuality that caused her to wet her bed.[73] Two children had been taken away from their neglectful parents during their oedipal stage to live in a children's home or with foster parents. Nervous and retarded 12-year-old Kees had experienced cold showers because of his *enuresis nocturna* in a children's home.[74] Weakly gifted and sexually awakened Trijntje, now 14, had been sent away by five foster families because of the same reason.[75]

Loveless and harsh stepmothering could cause the kind of "serious neurotic depression" based on "affective neglect" that could make a child wet his bed well into teenage. Fourteen-your-old Roelf, whose EEG did not show abnormalities, had been locked up in a barn with his brother by his first stepmother because "they were like dogs", after his mother had died when he was six. Fortunately, his new stepmother was helpful and kind, although Roelf did not like her either.[76] An even sadder story is to be found in the dossier of 11-year-old Wim, who was brought to the clinic by an older sister because his stepmother "did not want to have him in the house any more" because of the nasty smell. "For such a child I do not feel love any more", an accompanying letter said. Wim arrived in such a deplorable condition, that Hart de Ruyter informed the child's general practitioner and a child protection officer about it. Wim's EEG did not show irregularities, but the Bourdon attention test indicated "epileptiform lapses of consciousness". Rorschach showed Wim's feelings of opposition towards his stepmother, while his drawings of trees illustrated his feelings of loneliness and depression, we learn from Hart de Ruyter's reports. Wim was hospitalised for two weeks, during which he wet his bed only three times and the observation confirmed the diagnosis of a serious neurotic depression. The team advised sending the boy to a youth camp for a few months, during which time he might recover and parental rights might be taken from his father, who was seriously

[73]Dossier no. 52 (1955).
[74]Dossier no. 57 (1951–1953).
[75]Dossier no. 48 (1957).
[76]Dossier no. 36 (1953–1955).

criticised for his far too strict approach of this frustrated, neglected, inhibited and nervous victim of what the psychiatrist called a "stepmother situation".[77]

## Anxieties

Anxieties causing serious trouble to children, such as sleeping problems or fears that they or their parents might die, were the reason to apply for help at the Groningen clinic in 18 cases; 11 were boys, 6 were girls. These children were aged 8 to 14 when they first visited the clinic, with an average age of 12. Seven of these children received medication to make them feel more secure and 8 were submitted to an EEG-examination, 6 of whom did not show any irregularities. Only 11-year-old Louis was found with an "epileptic component" in the functioning of his brain, whereas in the final analysis his neuroticism was judged a far more important factor behind his problem behaviour. Although nervousness ran in the family, his anxieties, fits of anger, bed-wetting, and aggression had been inspired by his recently deceased father, who used to hit him, with the consequence of strong feelings of inferiority.[78] Thirteen-year-old Jannes, whose mother was a multiple sclerosis (MS) patient, was so afraid that she would die, that he could not sleep, had fits of anger, and fell far behind at school. To us, these circumstances seem enough for a child to become mentally ill. Nevertheless, Hart de Ruyter points to hereditary conditions, such as cases of nervousness in both families, an aunt with religious mania and a maternal aunt who attempted suicide and was therefore admitted to a mental hospital. The mother's MS is, moreover, mentioned in between references to the latter two cases of mental illness, suggesting that her own condition was likewise (partly) a mental one. Jannes's EEG was qualified as "regulatory instable", which made Hart de Ruyter draw the conclusion that he suffered from "organic brain dysfunction". His main problem, however, were his neurotic "feelings of insufficiency", caused by his failing to meet his parents' expectations.[79]

Apart from such, more complicated cases of mixed "organic" and neurotic causes of a child's trouble, other cases of anxiety were evaluated as purely neurotic. In only one case – of 11-year-old nervous, anxious and sleep-disturbed Berend – a slight hint of physiological (natural) determination is given; he is said to have a "pyknic" physical appearance and to suffer from an "endogenous depression", which was remedied with medication (plexonal).[80] Sedatives or sleeping pills were also given to six other children. According to Hart de Ruyter anxieties were typical of children's care pupils. One of these, 13-year-old Clara, was taken away from her mother, a prostitute, at the vulnerable age of three. Living in a foster family she became convinced that "nobody loved her". Her "narcissistic relational disorder" was expressed in nervousness, many anxieties, and a constant search for acceptation and affection, which in turn was easily wounded. A therapeutic foster family might help her overcome these problems, we read in the advice, next to periodical talks with a psychiatrist.[81]

[77]Dossier no. 54 (1954).
[78]Dossier no. 61 (1953–1955).
[79]Dossier no. 8 and 68 (1955).
[80]Dossier no. 77 (1954–1956).
[81]Dossier no. 60 (1957).

Too much strictness was mentioned often as cause of anxieties in the child-rearing literature of the 1950s. It could hurt a child's sense of security, even if it was practised by a loving and caring parent, Hart de Ruyter and others warned. Nine-year-old Josje was so afraid to go to sleep in the dark that she clung obsessively to all kinds of rituals and had developed psychosomatic complaints, such as rheumatism in her joints and tightness of the chest. According to Hart de Ruyter, who treated her for more than four years, she felt guilty about her secret masturbation. The girl's neuroticism could, according to his report, best be treated by convincing the parents to change their attitude and loosen their "too strict and orderly" style of child rearing – a task for the clinic's recently appointed social worker.[82] Another case of pre-adolescent fear of going to sleep, next to excessive masturbation, even at school, concerns 12-year-old Albert, who was afraid to be poisoned and feared that his parents would run away because of his bad school results. He had been admitted to the children's ward twice, without any improvement of his condition, before Hart de Ruyter referred him to the child psychologist of the university to be examined. In this case he did not elaborate on the parents' attitude but on an early childhood experience of Albert, who had been hospitalised at age one because of eczema for six weeks, while his parents had not been allowed to visit him during the first two weeks.[83] By telling this story the psychiatrist gave a clear hint, in 1955, that the boy's "basic security" was likely to have been shaken in the pre-oedipal stage much more seriously than his brain had been at age eight, after having fallen on the ice.

## Conclusion

Although similarities abound between Hart the Ruyter's theoretical work and his clinical practice as regards the diagnosing and treatment of children struggling with one of the three most frequently presented children's behavioural problems, some striking differences also manifest themselves. Both theoretically and in his busy clinical work he did not accept the untreatability of a mentally ill child and declined the idea of a "hopeless case". Two childhood stages stand out as particularly risky in terms of the development of mental illness: the pre-oedipal stage when "affective neglect" could easily disturb the healthy development of an infant's "basic security". Pre-adolescence was another risky stage, during which the ripening of a healthy Ego and Super-Ego could be disturbed by unhealthy coping-strategies such as would-be adaptation, caused by parental authoritarianism, harshness, strictness, or demandingness, all of which might inspire feelings of inferiority or insufficiency. The development of sexual desire might, moreover, trigger feelings of guilt, that could likewise block a healthy development during these years of ripening of a child's individuality. The labelling of this stage as risky is consistent with the age at which children and their parents applied for help at the child psychiatric clinic (11 or 12 on average), in the way the psychiatrist's aversion of strictness in child-rearing is consistent with his observation of authoritarianism or demandingness as source of behavioural problems originating during pre-adolescence. Another similarity lays in the ease with which conclusions were drawn as regards causes

[82]Dossier no. 63 (1954–1958).
[83]Dossier no. 66 (1955).

of the trouble: both theory and practice were prejudiced in favour of "affective neglect", but clinical practice needed few indications for the psychiatrist to also assume an organic cause. Diagnosing was no matter of prolonged consideration.

These conceptions and corresponding diagnoses are all inspired by relatively fresh "fruit" from the psychoanalytic manger, particularly ideas of Anna Freud, August Aichhorn, and John Bowlby. And all of these focus on parent–child interaction (nurture). However, Hart de Ruyter also clung strongly to his medical background, which made him use two new and innovative devices, the use of which implies a deviation from his predominantly Freudian theoretical position. First, the EEG to find out about possible epileptic or only slightly irregular functioning of a child's brain in the diagnostic process, an asset of which only academic hospitals could avail at the time. Second, medication, particularly sedatives and amphetamine, as therapeutic instrument. Amphetamine had only recently been discovered in the US as an effective drug in the treatment of overactivity and distractibility in children. While his writing shows no more than a very limited (though increasing) belief in medication, his practice shows a much more frequent use of this means than one would expect, given his psychoanalytic orientation. Both means demonstrate his belief in physical or natural causes of behavioural problems and in psychotropic drugs as a therapeutic instrument. However, one gets the impression that he used these means also because of practical reasons: an EEG could rule out brain dysfunction and medication could quickly create improvement of a child's behaviour, that might not easily be reached by means of lengthy psychotherapy, an approach that fitted the reality of waiting lists and admission freezes. The frequent use of these two biological means implies a significant difference between theory and practice, in that organic causes of behavioural problems were more frequently identified and psychotherapy as treatment was more often replaced with a prescription of drugs in the clinic. This use also shows that theory and practice mutually influenced each other and that therapeutic success could inspire changes in the theory. Finally, this use marks a clear difference with child psychiatry as practised at child guidance clinics, where an EEG could not be made and medication was used only very rarely at the time.

The use of these physically oriented instruments corresponds with the relatively frequent mentioning of organic or natural causes of behavioural trouble in children in the clinic's dossiers: hereditary predisposition, brain dysfunction, an unfavourable temperament, or an inborn or acquired neurological condition. These are most frequently mentioned in relation with school problems of children of normal intelligence. According to Hart de Ruyter's theory these could be caused by a congenital partial defect, an unfavourable temperament, physical illness, attention deficit, or a developmental delay, to which he later – after having used EEG examinations for some years – added neurological causes such as epilepsy and brain damage. In his clinical practice these figured next to the nurture-bound causes, such as emotional conflict caused by a disharmonious or neurotic family, parental discouragement or affective neglect, that also figured prominently in his theoretical work. This mixed aetiology in diagnosing children with school problems, went together with therapeutic optimism as regards the possibilities of remedial teaching, special education, and sometimes medication. Cases of pure neuroticism were few. Mostly, learning disabilities were interpreted as having both a natural and a nurture-bound basis, such as "an oedipal conflict on an epileptic basis".

Theoretically bed-wetting and anxieties were both conceived of as brought about by neuroticism. In the clinical practice, however, bed-wetting children were also frequently EEG-examined – one third of our cases as against one half of the learning-disabled children – but much less frequently found with any irregularity in the brainwave pattern. This means that a neurological dysfunction was sought for even when it was considered unlikely to be found. Remarkably many bed-wetters had a step-parent and felt unloved. They were easily diagnosed with a neurotic depression, which did not preclude the prescription of medication to make them sleep less deeply. Anxious children were hardly ever found with any organic cause of their trouble, such as a nervous temperament running in the family, but even they were sometimes treated with medication to make them feel more secure.

This makes us draw the conclusion that both theory and practice and both aetiology and treatment mixed up nature and nurture. The use of the quick means of an EEG to rule out organic causes and of medication to speed up improvement of a child's behaviour does, however, not undo the predominant adherence of the clinic's staff to updated versions of Freudianism. Like the use of apparently incompatible theories, it also demonstrates the semi-improvisational nature of early academic child psychiatry.

## Disclosure statement

No potential conflict of interest was reported by the authors.

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